State of Kansas

Open Enrollment

2004

October 1, 2003 through October 31, 2003

Health Care Commission – http://da.state.ks.us/ps/benefits.htm

QUICK REFERENCE GUIDE

MEDICAL PROVIDERS

Kansas Choice	Outside Topeka	800-332-0307
	In Topeka	785-291-4185
Coventry Health Care	Kansas City Area	800-969-3343
	Wichita Area	866-320-0697
Kansas Prefer	All locations	800-882-3639
Preferred Health Systems	Outside Wichita	866-618-1691
	In Wichita	316-609-2555
Preferred Plus of Kansas	Outside Wichita	866-618-1691
	In Wichita	316-609-2555
Premier Blue	Outside Topeka	800-332-0028
	In Topeka	785-291-4010

LAB CARD SERVICES

Lab*One*	All Areas	800-646-7788

DENTAL PROVIDER

Delta Dental Plan of Kansas	Outside Wichita	800-234-3375
	Wichita	316-264-4511

PRESCRIPTION DRUG PROVIDER

AdvancePCS	All Areas	800-294-6324

VISION PROVIDER

Superior Vision Services	All Areas	800-507-3800

FLEXIBLE SPENDING ACCOUNTS

ASI	All Areas	800-366-4827

EMPLOYEE BENEFITS GUIDEBOOK - Resource for Health Plan policies and procedures

Service provider web site links can be found at:

http://da.state.ks.us/ps/subject/benlink.htm

Note:

The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The Health Care Commission reserves the right to suspend, revoke or modify the benefit programs offered to employees. Nothing in this booklet shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.

GENERAL INFORMATION

Welcome from the Governor 1
Plan Year 2004 Offerings 2
Education and Communication 3
Employer and Employee Contributions 3
Effective Date, Coverage Period and Deductions 4
Plan Design Changes for 2004 4
Health Plan Options by County (Map) 7
Health Plan Comparisons by Type of Plan 8
How to Choose Health Care Coverage 12

HEALTHQUEST

Health Risk Appraisal Credit 12
Disease Management 13

HEALTH PLAN PROVIDERS

Medical Plans 14
- Health Maintenance Organization Information 14
  - Coventry Health Care 15
  - Preferred Plus of Kansas 16
  - Premier Blue 17
- Preferred Provider Organization Information 18
  - Kansas Choice 19
  - Kansas Prefer 20
  - Preferred Health Systems Insurance Company 21
- Lab Card Services 22
  - Lab One 22
- Prescription Drug Plan 23
  - AdvancePCS 23
- Dental Program 25
  - Delta Dental Plan of Kansas 25
- Vision Program 28
  - Superior Vision 29
- Hearing Improvement Program 30

KANELECT FLEXIBLE BENEFITS PROGRAM

- Pretax Premium Option 31
- Flexible Spending Accounts 31

OPEN ENROLLMENT INSTRUCTIONS

- On Line Enrollment 32
- Required Information 33
- Open Enrollment Check List 34

Message from the Governor

I am pleased to join the State of Kansas Health Care Commission in announcing the 2004 Health Plan. Our goal is to provide Health Plan participants with comprehensive, cost-effective choices.

We are all concerned with increasing medical costs. I commend the Health Care Commission for their efforts in making the most of our limited resources and their work to hold down the premium increases.

In these difficult financial times, I am pleased that the State approved increased funding for the state employee medical plan. However, it was not enough to avoid some benefit changes. While you may see an increase in premium, it is still below the national inflation trend for health care.

Most of us do not really take time to understand our benefits until we need them. I am asking participants to become wise health care consumers and active partners with the State of Kansas in controlling health care costs. This booklet offers many tools to assist you as you decide which health care plan may best suit you and your family this next year.

One significant improvement that I would call to your attention is that the wellness programs were improved in all the plans. Seeking preventive services not only will keep you healthier but will also result in lower out-of-pocket expenses for you.

The State continues to allow you to pay your premiums with pre-tax dollars and to set aside funds in a pre-tax account for qualified medical expenses. Some examples are expenses such as deductibles, copays and coinsurance that are not covered by the health plan. The pre-tax account, called the Health Care Flexible Spending Account, can assist you in paying for medical expenses and have a significant impact on your tax liability. I encourage you to check with your human resources director to learn more about the advantages of the Health Care Flexible Spending Account.

Thank you for the service you give to the people of Kansas. I hope you are satisfied with the choices of health plans provided for you and your family. If you have problems or concerns, please talk with your human resources director. We want to be sure State of Kansas employees are confident and comfortable with the health care options provided.

Kathleen Sebelius

Plan Year 2004 Offerings

Medical Plans

The Health Plan will offer two (2) types of designs and six (6) providers for Plan Year 2004.

- Health Maintenance Organizations (HMO):
  - Coventry Health Care
  - Preferred Plus of Kansas
  - Premier Blue
- Preferred Provider Organizations (PPO):
  - Kansas Choice - administered by Blue Cross Blue Shield
  - Kansas Prefer - administered by Harrington Benefit Services
  - Preferred Health Systems Insurance Company (PHSIC)

Lab Card Services

LabOne card for participants in Kansas Choice or Kansas Prefer plans.

Dental Plan

Delta Dental Plan of Kansas

Prescription Drug

AdvancePCS

Vision Plan (Optional)

Superior Vision Services

KanElect - Flexible Spending Accounts

Administered by ASI

Health Risk Appraisal (HRA)

MOST Healthcare Systems

There may be some changes in participating service providers. Participants should check the website or contact the plan for specific information.

Education and Communication

Participants are encouraged to read this Open Enrollment Booklet. It provides information about the plan options and assists in making wise decisions. The Health Benefits Administration staff, the Health Plans, agency Human Resources staff and the Division of Personnel Services web pages (and links) are all available to assist in understanding the choices available.

Open Enrollment Dates and Meetings

Open Enrollment for Health Plans and Flexible Spending Accounts begins on Wednesday, October 1, 2003 and continues through Friday, October 31, 2003. Employees are strongly encouraged to attend an Open Enrollment meeting scheduled at locations throughout the State. Selected meetings will be attended by provider representatives and Health Benefits Administration staff.

Open Enrollment Elections will become effective on January 1, 2004 for Health Plans and Flexible Spending accounts.

Open Enrollment using "Employee Self Service Center"

Enrollment for Plan Year 2004 is through the State Employee Self Service Center web site in the State of Kansas Information network, known as "accessKansas". Please review the open enrollment section of this booklet.

You must log in to the online Self Service Center

- To change, add or drop your health plan election for 2004, change your coverage elections or add or drop dependents from coverage.
- To register for Health Risk Appraisal participation.
- To change pretax payment status or enroll in Flexible Spending Accounts (FSA). Employees participating in either the Dependent Care or the Health Care FSA(s) through KanElect must complete a new election to participate for 2004.
- To review current elections for accuracy (even if you are not making changes).

Other Resources for Health Information

There are several valuable, informative resources available to plan participants to assist you in managing your health. A few of them are listed below.

http://www.collaborativecare.net links to more than 20 good health resources

http://www.ama-assn.org is the website of the American Medical Association

http://www.nih.gov is the website of the National Institutes of Health

http://www.cdc.gov is the website of the Centers for Disease Control

http://www.npsf.org is the website of the National Patient Safety Foundation

Employee Advisory Committee

The Employee Advisory Committee (EAC) is composed of 21 members including active employees and retirees. Each member serves a three-year term. Members are selected on the basis of geographic location, agency, gender, age, and plan participation. This is to assure that the membership represents a broad range of employee and retiree interests. The Committee provides a vehicle for participants to express ideas and concerns about the Kansas State Employees Health Plan to the Health Care Commission (HCC) and its staff. The EAC accomplishes this through regular meetings with the HCC staff, attendance at the HCC quarterly meetings, involvement in the carrier selection process and frequent and open communication with the Health Benefits Administrator. Health Plan participants are encouraged to contact any of the EAC members in order to provide ideas and suggestions for improvement to the Health Plan. For more information see http://da.state.ks.us/hcc/advisory.htm

Employer and Employee Contribution for Cost of Coverage and Rate Charts

The state contributes toward the cost of health coverage. Currently, for full-time employees, the employer share is approximately 95% of the cost of single coverage and 35% of the cost of dependent coverage.

To encourage competition among health plans as well as to encourage wise consumerism by plan participants, the State has a modified contribution approach beginning with Plan Year 2004. The State has been divided into two areas – one where HMOs are available, and one where only PPOs are available. In each area, the employer contribution will be based on the lowest cost plan in the area. An employee can select from among the plans available in the county where they live. If the plan selected is not the lowest cost option, the participant will pay the difference, or "buy-up" to the plan of their choice.

Employees currently enrolled in the lowest cost HMO will see their contributions increase by 10%. This results in a semi-monthly premium increase of between $1.00 to $20.00 for full-time employees depending upon the salary range of the employee and coverage level selected. The other two HMOs will cost an additional $2.25 to $12.00 semi-monthly and the PPOs will be available for an additional $10.00 to $81.00 per semi-monthly deduction.

In the PPO only area, the lowest cost plan will increase by 9%, or from $1.00 to $18.00 semi-monthly for full-time employees. The other PPOs will be available for an additional cost of between $10.00 to $54.00 per semi-monthly deduction.

Rate charts are located in the medical plan sections of this booklet. The rates listed for each medical plan include the cost for medical and prescription drug coverage only. Dental and vision rates are listed separately in those sections.

Participants who enroll in the Health Risk Appraisal agree to take a health screening and complete the online Health Risk Appraisal. Participants in the Health Risk Appraisal receive a $5.00 credit per semi-monthly payroll deduction period. The Health Risk Appraisal credit is applied to the dental rate for administrative purposes only. See the section on the Health Risk Appraisal for more information.

Effective Date, Coverage Period and Deductions

Effective Date

All Open Enrollment coverage elections for Plan Year 2004 become effective on January 1, 2004.

Coverage Period

Health Plan coverage is monthly. New enrollments or changes in enrollment and/or coverage will generally begin on the first day of the month. Terminations of coverage or ineligibility for coverage will be effective on the last day of the month.

Pre-Existing Conditions

The State of Kansas does not apply a waiting period for pre-existing conditions for newly eligible enrolled employees and their dependents.

Deductions

Employee contributions for the Health Plan and KanElect FSA's are deducted on a semi-monthly basis, or 24 (16 for certain Regents employees) times per year. For example, the deduction from the first paycheck in January will pay for the first half of January's coverage; the deduction from the second paycheck in January will pay for the second half of January's coverage. There will not be a Health Plan or KanElect FSA deduction on the third paycheck of those months during plan year 2004 which have three paychecks (January, July and December).

Identification Cards

New identification cards will be mailed as outlined below. Cards are mailed to the employee's home address starting in mid-December 2003.

- Medical ID cards will be sent to those employees who are either changing medical plans or changing coverage level with their current medical plan.
- Prescription Drug ID cards with new identification numbers will be sent to all participants.
- Dental ID cards will be sent only to those employees who are adding new coverage.
- Vision ID cards will be mailed to new enrollees.
- LabOne ID cards will be mailed to participants who enroll in Kansas Choice and Kansas Prefer PPO plans.

If an employee has not received a new ID card as listed above by the first part of January, the employee should contact the health plan at the telephone number listed in the front of this booklet to request one.

Plan Certificates

The information in the Medical Plan Comparisons by Plan Type chart is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the Certificate of Coverage which is the controlling document. Determinations of entitlement to benefits are made based on the Certificate of Coverage. Plan participants should review the Certificate of Coverage if they have any questions about benefits. The Certificates of Coverage may be viewed on the web page at http://da.state.ks.us/ps/subject/benlink.htm

Plan Design Changes, Plan Year 2004

There are plan design adjustments for Plan Year 2004. The following information summarizes the most notable adjustments by plan type and is not intended to be a complete representation of plan coverage. Participants are encouraged to review the more detailed side by side comparison located in this booklet.

Preferred Provider Organizations (PPO):

Kansas Choice

Kansas Prefer

Preferred Health Systems Insurance Company

Deductibles (annual):

- Network deductible eliminated
- Non-network deductible changed to $500 (single)/ $1500 (family of three or more)

Copayments:

- Office visit: Changed to coinsurance (from copayment in Kansas Prefer and Preferred Health Systems)
- Emergency Room: changed to $100/visit plus coinsurance (Network); $100 plus deductible and coinsurance for non-network.
- Inpatient services: Network: $300 copayment per admission plus coinsurance; no deductible. Non-network: $600 copayment per admission plus coinsurance; no deductible.

Coinsurance percentage:

- For Kansas Choice and Kansas Prefer: tiered coinsurance of 50% to a predetermined threshold, followed by 30% until maximum coinsurance reached.
- For Preferred Health: Coinsurance of 50% until maximum coinsurance reached.

Coinsurance Maximums (annual coinsurance; does not include deductible or copayments):

- Varying adjustments depending on the plan, but with a maximum of : Network: $2,200 single/$4,400 family; and Non-network: $3,650 single/$7,300 family.

Miscellaneous:

- Preventive services (network): Added $300 allowance or benefit to Kansas Choice; same as Kansas Prefer and PHSIC.
- Preventive services are not covered out of Network.
- Durable Medical Equipment: For Kansas Choice, total benefit increased to $4,500 per person.
- Hospice: Total benefit increased to $7,500 per person.

Health Maintenance Organizations (HMO):

Coventry

Preferred Plus of Kansas (PPK)

Premier Blue

Copayments:

- Office visits indexed to $20 for PCP and $30 for specialist.
- ER visit indexed to $75 plus 10% coinsurance
- Urgent care visits indexed to $30
- Inpatient services: $200 per admission plus 10% coinsurance
- Ambulance services: 10% coinsurance
- Major diagnostic tests: $100 per test plus 10% coinsurance
- Outpatient surgery: $100 per surgery plus 10% coinsurance

Coinsurance:

- 10% for designated services (copayments applied for some services as well)
- Annual coinsurance maximum: $1,000 single/$2,000 family (does not include copayments)

Miscellaneous:

- Preventive care services as approved by PCP (subject to copayment)

Dental Plan (Administered by Delta Dental of Kansas)

- Annual deductible for major services indexed to $45 per person/$135 family.
- Annual benefit level indexed to $1,600.
- Network expanded to DeltaUSA DPO national network.

Prescription Drug Plan (Administered by AdvancePCS)

Coinsurance:

- Generic: 20%
- Preferred brand: 35%
- Non-preferred: 60%
- Special case: indexed to $75

Coinsurance Maximums (annual):

- Maximum indexed to $2,580 (generic, preferred brand and special case only).

Health Risk Appraisal (HRA)

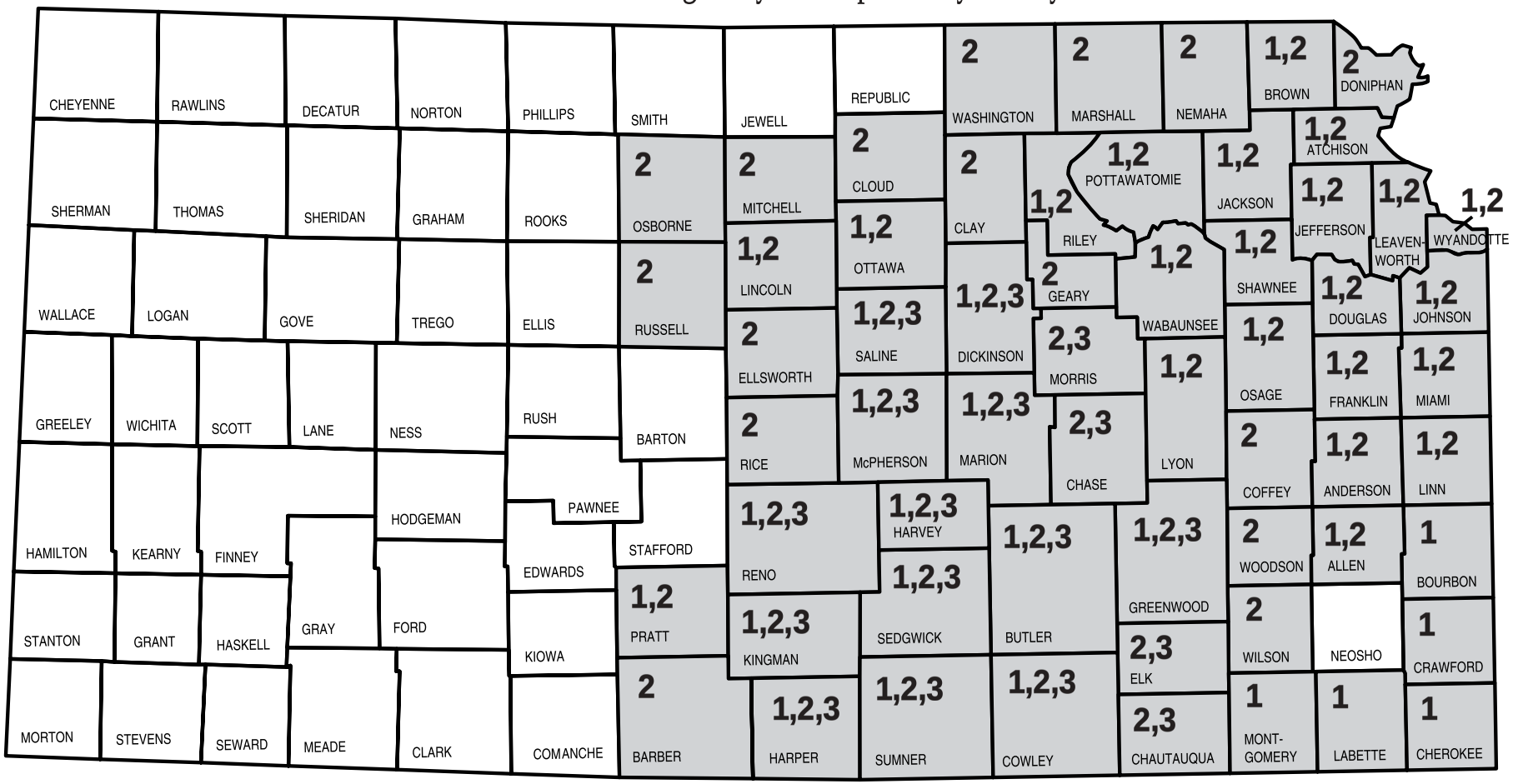
The HRA for employees will be continued for Plan Year 2004. It will be available for those who completed the participation requirements in 2003, waived enrollment in 2003 or who are newly eligible for this $5 semi monthly credit.

Vision Plan

Enhanced Plan changes:

- Progressive lens coverage allowance of $165 added.
- High Index lens coverage with allowance of $116 added.
- Polycarbonate lens coverage with allowance of $116 added.
- Only one lens allowance may be used per purchase.

2004 Enrollment Eligibility Plan Options by County



Eligibility for enrollment in Kansas Choice, Kansas Prefer, and Preferred Health Systems Insurance Company is in all counties in Kansas and Missouri and in most other states. Check with each of these health plans for locations of contracting physicians and provider networks.

Eligibility for HMO enrollment is listed on the Kansas map above and in the Missouri counties listed below. Kansas HMO counties shaded.

Key

1 = Coventry Health Care
2 = Premier Blue
3 = Preferred Plus of Kansas

Missouri

Andrew - 1
Benton - 1
Buchanan - 1,2
Caldwell - 1
Cass - 1
Clay - 1,2
Clinton - 1
Daviess - 1
DeKalb - 1
Henry - 1
Jackson - 1,2
Johnson - 1
Lafayette - 1
Platte - 1,2
Ray - 1

Plan Year 2004 Comparison Chart

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Deductible (not included in coinsurance maximums)	n/a	Network n/a	Non-Network $500 single/$1,500 family	Network n/a	Non-Network $500 single/$1,500 family
Coinsurance 1	10%	Network 50%	Non-Network 50%	Network 50%	Non-Network 50%
Coinsurance Maximum 1 (does not include deductible or copayments)	$1,000 single/$2,000 family	Network $1,100 single/ $2,200 family	Non-Network $1,450 single/ $2,900 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family
Coinsurance 2	n/a	Network 30%	Non-Network 30%	Network n/a	Non-Network n/a
Coinsurance Maximum 2 (does not include deductible or copayments)	n/a	Network $1,100 single/ $2,200 family	Non-Network $2,200 single/ $4,400 family	Network n/a	Non-Network n/a
Total Coinsurance Maximum (does not include deductible or copayments)	$1,000 single/$2,000 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family	Network $2,200 single/ $4,400 family	Non-Network $3,650 single/ $7,300 family
Copayment Summary - see specific category for detail on copayments.		Network	Non-Network	Network	Non-Network
Physician Office Visit	$20 PCP / $30 Specialist	n/a (Coins. applies)	n/a	n/a (Coins. applies)	n/a
Outpatient Mental Health (Biologically Based)	$25	$25	$25	$25	$25
Inpatient Services*	$200 per admission	$300 per admission	$600 per admission	$300 per admission	$600 per admission
Emergency Room Visit*	$75	$100	$200	$100	$200
Urgent Care Facility Visit	$30	n/a	n/a	n/a	n/a
Outpatient Surgery*	$100 per surgery	n/a	n/a	n/a	n/a
Major Diagnostic Tests*	$100 per test	n/a	n/a	n/a	n/a
Lifetime Benefit Maximum	$2,000,000 per person	$2,000,000 per person	$2,000,000 per person		
Primary Care Physician (PCP)	PCP manages and/or directs all care.	PCP not required.		PCP not required.	
Provider Choice	Local Network. Referrals required for care not by Primary Care Physician.	Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.		Freedom to use provider of choice. Benefits based on plan description. Coverage level based on provider network status.	
Out of Network Care	Must be referred by PCP and pre-approved by Health Plan. Subject to coinsurance and applicable copayments	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
Out of Area Care	Covered only for initial treatment of medical emergency or if pre-approved by Health Plan. Subject to coinsurance and applicable copayments.	Subject to deductible, coinsurance and applicable copayments		Subject to deductible, coinsurance and applicable copayments	
Amounts Above Plan Allowance	Provider to write off	Network Provider to write off	Non-Network Member responsibility	Network Provider to write off	Non-Network Member responsibility

* These copayments not included in coinsurance maximums. These services may require coinsurance.

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Inpatient Services	$200 copayment per admission, then subject to coinsurance. Copayment does not apply towards coinsurance maximum.	Network $300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Non-Network $600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum	Network $300 copayment per admission, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Non-Network $600 copayment per admission, then subject to coinsurance. Deductible does not apply. Copayments do not apply towards coinsurance maximum.
Outpatient Surgery	Subject to $100 copayment per surgery, then subject to coinsurance. Copayment does not apply to coinsurance maximum	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Ambulance Services	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Major Diagstic Tests (includes but not limited to: PET Scans, MRI Scans, CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography)	Must be pre-approved by Health Plan. Subject to $100 copayment per test then subject to coinsurance. Copayment does not apply to coinsurance maximum.	Must be pre-approved by Health Plan Network Subject to coinsurance	Non-Network Subject to ded & coins.	Must be pre-approved by Health Plan Network Subject to coinsurance	Non-Network Subject to ded & coins.
Other Outpatient Services	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physician Office Visits	Subject to office visit copayment. $20 for PCP, $30 for all other office visits. Copayments do not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physician Hospital Visits	Subject to coinsurance	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Emergency Room Visits	$75 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Network $100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Non-Network $200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Network $100 copayment (waived if admitted) then subject to coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.	Non-Network $200 copayment (waived if admitted) then subject to deductible and coinsurance. Copayment does not apply towards coinsurance maximum. If admitted, inpatient benefits will apply.
Urgent Care Facility Visits	$30 copayment. Copayment does not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Home Health Care	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $5,000 per benefit period Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Hospice	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Subject to coinsurance.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Network Subject to coinsurance	Non-Network Subject to ded. & coins.

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Surgery / Anesthesia / Asst. Surgeon	Subject to applicable inpatient or outpatient copayments, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Physical Rehabilitation Services	Services must be pre-approved by Health Plan. Inpatient limited to 60 days. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Subject to coinsurance.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Outpatient limited to 180 consecutive days if improvement documented at 30-day intervals. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Durable Medical Equipment	Services must be pre-approved by Health Plan. Subject to coinsurance. Limited to $5,000 of covered services per person per year.	Services must be pre-approved by Health Plan. Limited to $4,500 of covered services per person per year. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	Services must be pre-approved by Health Plan. Limited to $4,500 of covered services per person per year. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Inpatient Nervous & Mental / Drug & Alcohol	Subject to inpatient copayment, then subject to coinsurance. Copayment does not apply towards. coinsurance maximum. 60-day limit per year.	Network Subject to inpatient copayment, then subject to coinsurance. Copayments do not apply towards coinsurance maximum.60-day limit per year.	Non-Network Subject to inpatient copayment, then subject to deductible and coinsurance. Copayments do not apply towards coinsurance maximum. 30-day limit per year.	Network Subject to inpatient copayment, then subject to coinsurance. Copayments do not apply towards coinsurance maximum. 60-day limit per year. maximum.	Non-Network Subject to inpatient then subject to deductible. and coinsurance. Copayments do not apply towards coinsurance 30-day limit per year.
Outpatient Nervous & Mental / Drug & Alcohol	First 3 visits @ 100%, next 22 visits - $25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards the first 25 visits. Network First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	Non-Network First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.	Both in and out-of-network visits will be counted visits. towards the first 25 visits. Network First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	Non-Network First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
Biologically Based Mental Health Conditions	Benefits same as medical conditions for biologically based mental health conditions.	Benefits same as medical conditions for biologically based mental health conditions.		Benefits same as medical conditions for biologically based mental health conditions.	
Preventive Care Services (One per calendar year for each service)	Must be provided by network providers. See specific categories below.	Network Preventive Care Allowance = 1st $300/person covered in full then subject to coinsurance.	Non-Network Not covered.	Network Preventive Care Allowance = 1st $300/person covered in full then subject to coinsurance.	Non-Network Not covered.
Well-Woman Care (office visit, PAP smear test, and STD testing as determined to be appropriate by the provider.)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostic tests covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.
Mammogram (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Must be provided by network providers. No referral required. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.
Well-Man Care (office visit and PSA blood test)	Must be provided by network providers. No referral required. Subject to office visit copayment. Copayments do not apply towards coinsurance maximum. Related diagnostics covered in full.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered

Comparison Chart cont.

	Health Maintenance Organization (HMO) Coventry Health Care, Preferred Plus of Kansas, Premier Blue	Preferred Provider Organization (PPO) Kansas Prefer - using the PHCS network, Kansas Choice - using the Blue Choice network		Preferred Provider Organization (PPO) Preferred Health Systems	
Periodic Adult Physical Exam	Must be provided by PCP. Subject to $20 PCP office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.	Network Applies towards Preventive. Care Allowance then subject to coinsurance	Non-Network Not covered.
Dietitian Consultation	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Routine Hearing Exam (Hearing aids NOT covered)	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.	Network Applies towards Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered.
Routine Vision Exam (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered	Network Applies toward Preventive Care Allowance then subject to coinsurance.	Non-Network Not covered
Age Appropriate **Bone Density Screening**	As approved by Primary Care Physician. Covered in full.	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered.	Network Applies towards Preventive Care Allowance then subject to coinsurance. Must be pre-approved by Health Plan.	Non-Network Not covered.
TMJ / Orthognathic Surgery	Not Covered under Medical - see Dental	Not Covered under Medical - see Dental		Not Covered under Medical - see Dental	
Custom Shoe Inserts	Not Covered - see KanElect	Not Covered - see KanElect		Not Covered - see KanElect	
Childhood Immunizations to Age 6	Covered at 100% as required by state mandate.	Covered at 100% as required by state mandate.		Covered at 100% as required by state mandate.	
Allergy Testing	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Antigen Administration (desensitization/treatment) - Allergy Shots	As approved by Primary Care Physician. Subject to applicable office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. Subject to $30 Specialist office visit copayment. Copayments do not apply towards coinsurance maximum.	As approved and precertified by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.	As approved and precertified by Health Plan. Network Subject to coinsurance	Non-Network Subject to ded. & coins.
Gastric Surgery and Other **Weight Loss Treatments**	Not Covered - see KanElect	Not Covered - see KanElect		Not Covered - see KanElect	
Prescription Drug Benefits (Provided by AdvancePCS) Coinsurance and Copayments copayment per perscription plan deductible or coinsurance maximum.	Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - $75 copayment per perscription Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - $2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications - Member pays 100% of the discounted price.	Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - $75 copayment per perscription Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - $2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications - Member pays 100% of the discounted price.		Tier 1: Generic - 20% coinsurance Tier 2: Preferred Brand - 35% coinsurance Tier 3: Special Case Medications - $75 do not count towards medical Coinsurance/Copay Maximum: Tiers 1, 2 & 3 only - $2,580 per person per year Tier 4: Non-Preferred Brand and Compounded Medications - 60% coinsurance Tier 5: Lifestyle Medications Member pays 100% of the discounted price.	
Dental Benefits	Provided by Delta Dental Plan of Kansas	Provided by Delta Dental Plan of Kansas		Provided by Delta Dental Plan of Kansas	

How to Choose Health Care Coverage

The State of Kansas Health Plan offers several health care options for its employees. It is important to understand the choices available in order to pick the right plan for you and your dependents. Before deciding on a health care plan, it is important to do the following:

- 1 Decide who is going to be covered.
- 2 Examine your health care needs. Are there any health conditions that need to be considered? Do you anticipate different health care needs in the coming year?
- 3 Do you travel out of state for extended periods or do you have dependents living (going to school) out of state?
- 4 Read through the Open Enrollment materials. If you do not understand something, ask your agency Human Resources officer and/or attend an Open Enrollment meeting.
- 5 Determine what medical providers (hospital & doctors) you would like to use for health care.
- 6 Ask your co-workers if they have used their health care program and how satisfied they are with their plan.
- 7 Note the cost of each program (both premium and out-of pocket expenses).

Choosing a Health Care Program

There are two types of health programs – Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO).

PPO programs offer you the ability to go to any doctor or hospital (more choice). PPOs have contracted networks. Not all doctors and hospitals are in each network. If you go to a doctor or hospital out of the network, you will still be covered but you will pay more for care. Review the network to see if the doctors and hospital you prefer contract with that health plan. If they do not, that plan option may not be the program for you. Ask yourself if you are willing to change doctors or hospitals in order to have this program. Take note of the out-of-network deductible and coinsurance.

An HMO program offers you a limited number of providers. You must select a Primary Care Physician (PCP) for yourself and each of your covered dependents. In the HMO program, you may not have coverage (except for emergencies) if you do not go through or are not referred by your PCP. When picking an HMO, remember the golden rule: Whatever happens medically, your first call is to your PCP. If you follow this rule, you will enhance your experience with an HMO. However, if you travel for extended periods or have dependents going to school or otherwise living out of state, an HMO may not be the best choice.

HealthQuest

Health Screening/Health Risk Appraisal Credit

For the second year, HealthQuest is offering an incentive to participate in the health screening program. Participants who enroll will receive a $5 semi-monthly payroll deduction credit on their dental premium during Plan Year 2004. **Employees must sign up during Open Enrollment in October 2003.**

The program consists of a health screening (HS) through MOST Healthcare Systems and includes tests for cholesterol, glucose, and other biometric measures. Participants may use lab test results from their own physician as long as they are within the past 6 months. The on-line Health Risk Appraisal (HRA) component consists of a questionnaire assessing general health parameters and lifestyle behaviors. These two components give participants a snapshot of their health risks and possible areas for improvement.

The HS results will be needed before going on-line to complete the HRA. The data will be entered into the HRA on a secure web site and participants will answer the remaining questions to complete the final step of the program. A software program will analyze the data and provide the participant with a confidential, individualized report of the results and educational information about making healthy lifestyle changes to reduce their health risks. A post card about how to sign up for the

Health Screening will be sent to everyone who signed up to participate in the Health Screening/Health Risk Appraisal program during Open Enrollment.

Disease Management

HealthQuest is partnering with AdvancePCS, the State's Pharmacy Benefit Manager, for the second year to offer disease management programs. Programs being considered for Plan Year 2004 will focus on identified areas for health improvement and offer programs designed to help people with these health issues to achieve optimal health. The goal of these programs is to assist eligible participants in maintaining or enhancing their health through self-care management and effective communication with their physician. The patient interventions include specific educational booklets, seasonal health reminder messages, medication cards, resource lists, telephonic outreach and other educational messaging. Some important facts to remember are:

- The programs are **totally voluntary**.
- The programs are **completely confidential** and no participant's personal medical information is shared with anyone at the State of Kansas or any other organization or business.
- The programs are offered **by invitation** and are **free to eligible participants**.

The Disease Management programs planned for Plan Year 2004 are asthma, diabetes, depression, and coronary artery disease. If you are eligible to participate, AdvancePCS will contact you. Participants may choose to opt out at any time.

HEALTH MAINTENANCE ORGANIZATION (HMO) INFORMATION

All HMO's offered by the State of Kansas offer standardized benefits as outlined in the Medical Plan Comparison chart located in this booklet. Each HMO has a certificate of coverage available for review on the website:

http://da.state.ks.us/ps/subject/benlink.htm To enroll for coverage in an HMO, the participant and all covered dependents must maintain primary residence within the service area for the plan selected. Refer to the Enrollment Eligibility Map for specific eligibility information.

ALL services require prior approval or referral by the participant's Primary Care Physician (PCP) except where noted otherwise.

Keys to Using HMOs

- **Employee should verify eligibility with the health plan before a PCP selection is made.** The provider directory is available at: http://da.state.ks.us/ps/subject/benlink.htm
- **Changes in PCP selection** can be made by calling the medical plan. Changes will become effective the first of the month following notification to the HMO plan.
- **Call your PCP before seeking treatment.** It is the PCP's responsibility to direct the treatment of the participant. If there is a medical need for care by a specialist, the PCP will authorize and coordinate the care.
- **All medical services must be coordinated through each covered participant's Primary Care Physician (PCP) or HMO plan.** This includes any treatment recommended by a specialist to whom the participant has been previously referred.
- **Any participant residing temporarily outside the enrollment area will be covered for emergency services only.**
- **All referrals from the participant's PCP to a specialist must be obtained PRIOR to the receipt of services.** If there is a medical reason for using a specialist that does not contract with the health plan, the participant's PCP must seek authorization from the HMO plan before a referral is made.
- **Well Woman Exam.** Women may visit an OB/GYN physician participating with their HMO plan for an annual well woman exam without a referral from their PCP.
- **Well man exam.** Men may visit a urologist/proctologist who participates with their HMO plan for an annual well man exam without a referral from their PCP.
- **All emergency room visits for emergency medical conditions** must be reported to the HMO plan within a specified period of time – usually 24 to 48 hours. In cases of life or limb threatening emergencies, the participant should seek help immediately. For non-life or limb threatening situations, the participant should call their PCP before seeking treatment.
- **Urgent care** or care needed on evenings, weekends, or holidays must be coordinated by the participant's PCP. The PCP (or a covering physician) will be available 24 hours a day.
- **Claims for treatment of dental accidents/injuries** must first be submitted to the dental plan for payment of covered services. The participant's PCP must refer for all specialty services subsequently eligible for coverage by the medical plan.
- **Out of area services** are limited to initial treatment of an accident or emergency. Routine or elective care is not covered outside the service area.
- **All non-emergency hospital admissions** must be authorized in advance by the HMO plan.

COVENTRY HEALTH CARE (HMO)

Coventry Health Care is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with Coventry Health Care, the participant and all covered dependents must maintain primary residence within the Kansas City/Topeka/Southeast service area or the Wichita/South Central Kansas service area. Counties added for 2004: Allen, Bourbon,Cherokee, Crawford, Labette, Lyon, Montgomery, Osage, Pottawatomie, Wabaunsee (KS) and Andrew (MO).

Mental Health/Substance Abuse benefits are coordinated by United Behavioral Health (UBH). The participant seeking care should call UBH (see number below). A separate referral from the member's PCP is not needed.

Mailing Address

Kansas City/Topeka Area:	Wichita/South Central Area:
Coventry Health Care of Kansas	Coventry Health Care of Kansas
8320 Ward Parkway	8301 East 21st Street North, Suite 300
Kansas City, MO 64114	Wichita, KS 67206

Customer Service Telephone Numbers

Kansas City/Topeka Area	800-969-3343
Wichita/South Central Area	866-320-0697
United Behavioral Health (UBA)	866-607-5970
FirstHelp	800-622-9528 (for health care inquiries)

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Please check the map on page 7 to determine if this plan is available in your county of residence.

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$8.50	$14.07	$19.47	$48.34
Emp/Spouse	$119.08	$124.64	$130.03	$173.21
Emp/Child(ren)	$96.96	$102.52	$107.91	$148.23
Emp/Family	$207.52	$213.08	$218.48	$273.12

Note: Mid America Health has been acquired by Coventry and will not be offered in 2004. Mid America Health participants will be automatically enrolled in Coventry at the same tier level unless they make a change during Open Enrollment.

PREFERRED PLUS OF KANSAS (HMO)

Preferred Plus of Kansas, Inc. (PPK) is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with PPK, the participants must maintain primary residence within the PPK enrollment area of south central Kansas.

Mailing Address

Preferred Plus of Kansas
8535 E. 21st Street North
Wichita, KS 67206

Customer Service Telephone Numbers:

Toll free: 866-618-1691
In Wichita: 316-609-2555
Behavioral Health Services 316-609-2541 in Wichita
866-338-4281 in all other areas

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Please check the map on page 7 to determine if this plan is available in your county of residence.

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$6.50	$12.06	$17.46	$46.33
Emp/Spouse	$115.06	$120.62	$126.01	$169.19
Emp/Child(ren)	$93.34	$98.90	$104.29	$144.61
Emp/Family	$201.89	$207.45	$212.85	$267.49

Preferred Health Systems

PREMIER BLUE (HMO)

Premier Blue is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with Premier Blue, the participants must maintain primary residence within the Premier Blue enrollment area.

Mental Health/Substance Abuse benefits are coordinated by Health Management Strategies (HMS). The participant seeking care should call HMS for authorization before services are received (see numbers below). A separate referral from the participant's PCP is not needed.

Mailing Address

Premier Blue
1133 SW Topeka Blvd.
Topeka, KS 66629

Customer Service Telephone Numbers:

Toll free 800-332-0028
In Topeka: 291-4010

Health Management Strategies

Toll free: 800-952-5906
In Topeka: 233-1165

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Please check the map on page 7 to determine if this plan is available in your county of residence.

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$4.25	$9.81	$15.22	$44.09
Emp/Spouse	$110.58	$116.14	$121.53	$164.71
Emp/Child(ren)	$89.31	$94.87	$100.26	$140.58
Emp/Family	$195.62	$201.18	$206.58	$261.22

PremierBlue

Preferred Provider Organization (PPO) Information

The PPO benefit structure has been re-designed for 2004. Kansas Choice will function as a PPO both inside and outside the State of Kansas. There will be significant differences in the networks of the three PPOs. Preferred Health Systems PPO will have a similar structure, but only one level of coinsurance as opposed to a tiered coinsurance approach applied by Kansas Choice and Kansas Prefer. Preferred Health Systems coinsurance is 50% until the maximum coinsurance is reached. Under Kansas Choice and Kansas Prefer, the coinsurance is 50% until half the coinsurance maximum is reached and then 70% until the full coinsurance maximum is reached. The PPO plan design will feature:

- First dollar coverage – In-Network ONLY (deductible applies to non-network services). From the very start of the plan year, benefits are available at a 50% coinsurance when using network providers.
- Preventive Care Allowance of $300 per person providing 100% coverage In-Network ONLY for specified preventive care services.
- Lab Card benefit through Lab*One* (Kansas Choice and Kansas Prefer only) providing 100% coverage for outpatient lab services billed through Lab*One*.
- Access to the provider of your choice – No PCP required. Reimbursement based on the network status of the provider selected.

The three PPO plans have a standardized benefit structure that is outlined in the Comparison Chart.

Keys to Using PPOs

- Provider Directories and Certificates of Coverage (insured plans) or Benefit Descriptions (self-insured plans) are available on the State of Kansas Web Site: **http://da.state.ks.us/ps/subject/benlink.htm**
- All claims are paid **based on the contracting status** of the provider of service at the time the service is performed.
- Ask your physician for the names of any other providers (i.e. anesthesiologist, assistant surgeon, laboratory, etc) that may be involved in your treatment. This allows the participant to check their contracting status before any services are performed.
- The PPO plans feature a ***Preventive Care Service Allowance*** of $300 per person per year for specified wellness services. This allowance applies only for routine wellness services provided by network or contracting providers. Services provided to treat an illness or by non-contracting providers will be subject to deductible and coinsurance.
- Participants may utilize a non-contracting provider. The plan will pay the claim based upon their allowed charge for the procedures. **The participant will be responsible for any difference between the plan allowance and the actual charge. This difference could result in additional out-of-pocket expenses for the participant.** Ask the provider if they will accept the plan's allowance as payment in full.
- Claims for the treatment of dental accidents/injuries must first be submitted to the dental plan for payment of covered services. Services covered by the dental plan are not eligible for reimbursement through the medical plan.

KANSAS CHOICE (PPO)

Kansas Choice is a self-insured plan administered by Blue Cross Blue Shield of Kansas (BCBSKS). BCBSKS is responsible for claims processing and customer service, network management and utilization review. **Benefits are summarized in the Comparison Chart.** The Benefit Description is posted on the web at http://da.state.ks.us/ps/subject/benlink.htm

Participants do not need to designate a Primary Care Physician (PCP). A nationwide network is available. For the Kansas City Metropolitan area, including Johnson and Wyandotte counties, network providers are those which contract as Preferred Care Blue Providers with BCBS of Kansas City. In all other locations, network providers are those which contract with the Blue Card PPO network. Links to the BCBS website and the provider directory are available at http://da.state.ks.us/ps/subject/benlink.htm. The initial link is to the BCBSKS directory, with further links to the Kansas City plan and the national Blue Card network.

Participants may seek care outside of the network benefits by using non-network providers, but they will pay a greater share of the cost when using non-network providers and facilities.

Mailing Address

Kansas Choice
Blue Cross Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Customer Service Telephone Numbers

Toll free: 800-332-0307
In Topeka: 785-291-4185

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

There are two different rates for the PPOs, depending on whether a participant resides in a county where an HMO is available. Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Check the map on page 7 to determine the region in which you live.

Rates for HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$19.33	$24.89	$30.29	$59.16
Emp/Spouse	$140.72	$146.28	$151.67	$194.85
Emp/Child(ren)	$116.44	$122.00	$127.39	$167.71
Emp/Family	$237.82	$243.38	$248.78	$303.41

Rates for Non-HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$10.01	$15.90	$21.62	$52.17
Emp/Spouse	$128.06	$133.95	$139.65	$185.36
Emp/Child(ren)	$104.45	$110.34	$116.04	$158.72
Emp/Family	$222.48	$228.37	$234.09	$291.91

BlueCross BlueShield of Kansas

KANSAS PREFER (PPO)

Kansas Prefer is a self-insured plan. Claims processing and customer service are administered by Harrington Benefit Services. Provider network and utilization review are administered by Private HealthCare Systems.

Participants do not need to designate a Primary Care Physician (PCP). The Private HealthCare Systems network includes over 390,000 professional providers and 3,600 facilities nationwide. In Kansas, including the Kansas City metropolitan area, there are over 130 facilities and in excess of 5,500 providers. Participants may also seek care outside of the network by using non-network providers, but they will pay a greater share of the cost when using non-network providers and facilities.

The Lob*One* lab card benefit has been added to the program.

Benefits are summarized in the Comparison Chart. The Benefit Description is posted on the web at http://da.state.ks.us/ps/subject/benlink.htm

Mailing Address

Kansas Prefer

P.O. Box 268941

Oklahoma City, OK 73126-8941

Harrington

A Fiserv Health™ Company

Customer Services Telephone Number

Toll free: 800-882-3639

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

There are two different rates for the PPOs, depending on whether a participant resides in a county where an HMO is available. Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Check the map on page 7 to determine the region in which you live.

Rates for HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$13.82	$19.38	$24.78	$53.65
Emp/Spouse	$129.70	$135.26	$140.65	$183.83
Emp/Child(ren)	$106.52	$112.08	$117.47	$157.79
Emp/Family	$222.39	$227.95	$233.35	$287.98

Rates for Non-HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$4.50	$10.39	$16.11	$46.66
Emp/Spouse	$117.04	$122.93	$128.63	$174.34
Emp/Child(ren)	$94.53	$100.42	$106.12	$148.80
Emp/Family	$207.05	$212.94	$218.66	$276.48

PREFERRED HEALTH SYSTEMS INSURANCE COMPANY(PPO)

Preferred Health Systems is a fully insured Preferred Provider Organization. Participants do not need to designate a Primary Care Physician (PCP). The Preferred Health Systems network includes nearly 4,000 providers in the state. The provider network is primarily a Kansas based network. Participants may seek care outside of the network benefits by using non-network providers, but they will pay a greater share of the cost when using non-network providers and facilities.

Benefits are summarized in the Comparison Chart. The Certificate of Insurance is posted on the web at http://da.state.ks.us/ps/subject/benlink.htm

Mailing Address

Preferred Health Systems Insurance Company
8535 East 21st Street North
Wichita, KS 67206

Customer Service Telephone Numbers

Toll free: 866-618-1691
In Wichita: 316-609-2555

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Employee's Cost of Coverage

There are two different rates for the PPOs, depending on whether a participant resides in a county where an HMO is available. Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period.

Check the map on page 7 to determine the region in which you live.

Rates for HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$33.02	$38.58	$43.98	$72.85
Emp/Spouse	$168.10	$173.66	$179.05	$222.23
Emp/Child(ren)	$141.08	$146.64	$152.03	$192.35
Emp/Family	$276.15	$281.71	$287.11	$341.74

Rates for Non-HMO Counties

Coverage Level	FT-1	FT-2	FT-3	PT
Salary Range	<$25,000	$25,000-$44,500	>$44,500	All part time
Employee only	$23.70	$29.59	$35.31	$65.86
Emp/Spouse	$155.44	$161.33	$167.03	$212.74
Emp/Child(ren)	$129.09	$134.98	$140.68	$183.36
Emp/Family	$260.81	$266.70	$272.42	$330.24

LAB CARD SERVICES

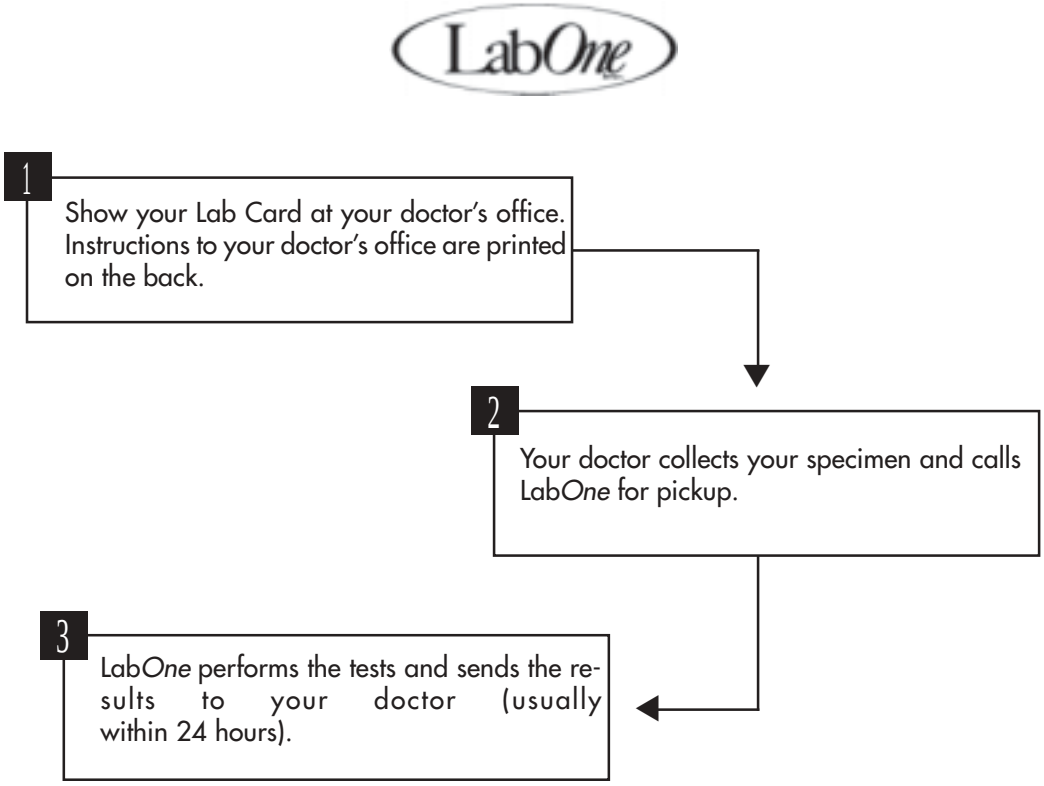
The Lab Card program through Lab*One* is new for 2004.

The State has contracted with Lab*One* to be a specialty vendor for the Kansas Choice and Kansas Prefer PPO plans. Lab*One* provides high quality lab services in such volume that the savings can be significant.

Beginning in January 2004, when a person enrolled in Kansas Choice or Kansas Prefer uses Lab*One* for outpatient lab work covered by the medical plan, the cost will be covered at 100% with no copay, no deductible and no coinsurance. This means that when your doctor orders laboratory tests for you or your covered dependents, the only thing that should come out of your wallet is your Lab Card/health care card.

Lab*One* may already be doing the lab work for your doctor. Many physicians throughout the State draw the blood samples in their office and send them to Lab*One* for testing. There are also a number of collection sites throughout the state that may be more convenient than going into your doctor's office.

Using the Lab*One* program is easy as 1-2-3….



Telephone:

1-800-646-7788

Website for Collection Sites

http://www.labcard.com

PRESCRIPTION DRUG PLAN

AdvancePCS is the Pharmacy Benefit Manager (PBM) administering the self-insured prescription benefit plan offered to participants of the State of Kansas Health Plan. AdvancePCS has a network of over 65,000 pharmacies nationwide available to plan participants.

Mailing Address (for paper claims)

AdvancePCS, Inc.

P.O. Box 853901

Richardson, TX 75085-3901

Customer Service Telephone Numbers

Toll free: 800-294-6324

TDD: 800-863-5488

Prescription benefits are included with all medical plans and the cost of this program is incorporated into the medical plan rates.

The full Benefit Description, preferred drug list (formulary) and other information related to the Prescription Benefit Plan are posted at: http://da.state.ks.us/ps/subject/benlink.htm. The preferred drug list (formulary) is updated throughout the year.

The Kansas State Employees Prescription Benefit Plan is a five tier program designed to encourage plan participants to partner with their physicians in choosing cost effective medications when needed for the treatment of illness or injury.

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Plan Coverage	Type of Prescription Medication	Participant Pays
Tier 1	Generic Drugs	**20% coinsurance**
Tier 2	Preferred Brand Name Drugs	**35% coinsurance**
Tier 3	Special Case Medications (1)	**$75 copay per fill**
Tier 4	Non Preferred Brand Name Drugs	**60% coinsurance**
Tier 5	Lifestyle Medications (2)	**100% of discounted price**
Coinsurance Max	Tiers 1, 2, & 3 purchases only	**$2,580 per participant/year**

(1) Very high-cost medications used to treat generally life-threatening conditions.

(2) Medications used primarily to enhance lifestyle rather than treat an illness or condition.

The coinsurance maximum of $2,580 per participant per year applies to the participant's coinsurance for Tier 1 – Generic, Tier 2 - Preferred Brand Name and the copay for Tier 3 - Special case medications. Once the coinsurance maximum is reached, claims are paid at 100 percent for Tiers 1, 2, & 3 drugs for the remainder of that calendar year.

The initial fill of any prescription is limited to a 30-day supply or one standard unit of therapy, whichever is less. Prescriptions can be refilled when 75% of the previous fill has been used. Medications may be refilled for up to a 60-day supply, or two standard units of therapy, if the prescription was written to indicate the larger fill and it is within 90 days of the previous fill for the same medication.

Mail Order Options

For your convenience, AdvancePCS offers a mail order option to obtain refills on your prescription medications. This is an especially useful benefit for those drugs you take on a regular basis. In many instances, you will pay less for medications obtained using the AdvancePCS mail order service due to greater discounts and lower dispensing fees. Mail service profile forms are available at http://state.ks.us/ps/benefits.htm

New prescriptions are also available by mail. AdvancePCS offers a *"FastStart"* program that allows your physician to fax your new prescription to AdvancePCS. In the *FastStart* program, your order can usually be shipped within 24 hours.

SpecialtyRx

An exceptional feature of the benefit plan is the SpecialtyRx program. This program focuses on patients who utilize medications identified as being given by injection, are used by small patient populations and are costly. The program offers members a convenient source for these high cost injectibles and supplies, lower potential drug-to-drug interactions and improved therapy compliance.

Patients who elect to participate in the AdvancePCS SpecialtyRx program will have access to pharmacists or nurses 24 hours per day, 7 days a week. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve the physician, case manager, clinical pharmacist, nurse and patient in a coordinated and monitored course of treatment. Of course, a patient may opt-out of the program if they desire.

DENTAL PLAN

The dental program is a self-funded plan administered by Delta Dental Plan of Kansas which is responsible for claims processing and customer service, network management and utilization review. All employees enrolled in medical coverage are also enrolled in the dental program. Employees may elect to purchase dental coverage for their dependents who are enrolled in the State Health Plan.

Sometimes more than one procedure is available which would restore the tooth to function, according to accepted standards of dental practice. If a more expensive service or benefit is selected over a less costly method, the plan will pay based upon the fee for the least costly method needed to restore function. The remainder of the fee will be the responsibility of the participant. Participants are encouraged to ask their dentist to send in a pre-certification on high cost and major restorative services being considered before work begins. Delta will review the course of treatment and advise you and your dentist of the benefits available for the proposed treatment. Benefits paid for treatment of an accident do not apply toward the annual benefit maximum for other covered services.

For treatment due to accidental injury, the dental plan will be primary. Only those services not covered by the dental plan may be submitted to the participant's medical plan subject to any requirements of that plan. No service will be covered by both the dental and medical plans.

Premier Network

The Delta Premier Network is the broad network of providers that participants may utilize. Delta Dental will make payment directly to the dental provider. The participant will only be responsible for paying the specific coinsurance and deductibles for covered services or for any services not covered.

DeltaUSA

In addition to the Delta Premier network, Delta Dental also offers the DeltaUSA DPO network. The DPO network providers have agreed to a reduced fee for providing dental services. The DPO network for our group has been expanded to include all DPO providers in the national DeltaUSA DPO network. All participants of the Delta Dental program may use the DPO providers whenever desired.

Non-Network

Participants may use a dental provider who does not contract with Delta Dental. Non-contracting providers may require payment at the time of service. The participant will then need to file their own claims and the plan payment will be mailed to the participant. Payment will be subject to applicable deductible and coinsurance and paid based upon the lesser of the actual charge or the customary fee for the service as determined by Delta Dental. Patients are responsible for the entire balance of charges not paid by Delta Dental.

Mailing Address

Delta Dental Plan of Kansas
P.O. Box 49198
Wichita, KS 67201-9198

Customer Service Telephone Numbers

Toll Free 800-234-3375
In Wichita 316-264-4511

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

DELTA PLAN (Cont.)

The coinsurance percentage listed is the amount paid by the Delta Dental Plan. Benefits are subject to the terms of the benefit description.

	DPO	Non- DPO
DIAGNOSTIC AND PREVENTIVE SERVICES: Oral examinations, prophylaxis/ cleanings (including periodontal maintenance) twice per plan year Diagnostic x-rays: bitewings twice per plan year for dependents under age 18 and once per plan year for adults age 18 and over. Full mouth x-rays once each five years. Topical fluoride twice per plan year for dependent children under age 19. Space maintainers only for the premature loss of primary molars and only for dependent children under the age of 9. Sealants are covered for dependent children under age 17 and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one per four years.	100%	100%
ANCILLARY: Provides for visits to the dentist for the emergency relief of pain.	100%	100%
REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations on posterior (back) teeth; composite (white) resin restorations on anterior (front) teeth; and stainless steel crowns for dependents under age 12.	80%	60%
The following procedures are subject to a $45 deductible per person per calendar year not to exceed an annual family deductible of $135:		
ORAL SURGERY: Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.	80%	60%
ENDODONTICS: Includes procedures for root canal treatments and root canal fillings.	80%	60%
PERIODONTICS: Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.	80%	60%
SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.	50%	50%
PROSTHODONTICS: Bridges, partial and complete dentures, including repairs and adjustments.	50%	50%
TMJ: Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. **A treatment plan must be pre-authorized by Delta Dental.**	50%	50%

ANNUAL MAXIMUM: The maximum paid by the plan for the above treatments is $1,600 per person per calendar year.

DELTA PLAN (Cont.)

ORTHODONTIC COVERAGE

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at 50% only when provided by a Delta Dental Plan participating dentist. Orthodontic treatments are not subject to a deductible and have a $1,000 per person lifetime maximum. The maximum for orthodontic services does not apply to the regular annual maximum for other covered services. To be covered, orthodontic treatment must start after the effective date of dental coverage.

DENTAL ACCIDENTS

Claims for treatment of dental accidents must first be processed by the dental plan. Services not covered by the dental plan can then be considered by the participant's health plan for additional coverage. Payment for treatment for an accident does not apply to the annual maximum for other services.

Employee's Cost of Coverage

Rates listed below are for Delta Dental coverage only per semi-monthly (i.e. 24) deduction period. Employees can reduce the premium for dental coverage by participating in the Health Risk Appraisal. Additional information is located in the Health Risk Appraisal section.

	Full Time Employee		Part Time Employee	
Coverage Level	HRA Participant	Non HRA Participant	HRA Participant	Non HRA Participant
Employee	$0.00	$5.00	$2.93	$7.93
Emp/Spouse	$7.06	$12.06	$10.94	$15.94
Emp/Child(ren)	$5.65	$10.65	$9.34	$14.34
Emp/Family	$12.71	$17.71	$17.35	$22.35

Note: The Health Risk Appraisal (HRA) credit is applied to the dental rates for administrative convenience.

VISION PROGRAM

Superior Vision Services Basic and Enhanced plans are fully insured voluntary vision programs. Employees may elect to enroll themselves and any eligible dependents in one of the vision programs, whether or not the employee or dependents are enrolled in State's medical coverage. However, if dependent vision coverage is selected and dependent children are also enrolled in the medical plan, the dependent children enrolled in vision must match those enrolled in the medical plan. Enrollment, even on an after-tax basis, cannot be changed during the Plan Year unless due to either a newly eligible dependent or to a dependent becoming ineligible.

Network Providers – How Superior Vision Service Works

To obtain vision care services under the Basic or Enhanced Plans, the participant should contact a Superior Vision network provider. At the appointment, show the ID card or simply indicate enrollment in Superior Vision and provide them the ID number. Superior Vision will pay the network provider for covered services and materials. The patient is responsible for any copayments and any additional costs resulting from cosmetic options, or non-covered services and materials selected.

If the participant has medical coverage through the State, the medical plan will cover one routine eye exam each year. To coordinate benefits with the medical plan, the Superior Vision provider will also need the name of the medical plan and the participant's plan identification number. To maximize benefits, participants need to make sure that their chosen provider is a network provider for both the vision and medical plans.

Non-Network Providers – How Superior Vision Works

Before a participant receives services from a non-network provider, they should contact Superior Vision Member Services Department at **1-800-507-3800** to receive an authorization number. After receiving services, the participant is responsible for paying the provider in full and submitting itemized receipts along with the authorization to Superior Vision. Reimbursement will be made according to the reimbursement schedule for non-network providers listed in the benefit description. It is important to note that the reimbursement schedule does not guarantee full payment.

Superior Vision's Additional Value

Discounts on additional eyewear

Discounts are available for additional eyewear purchases. The discounts range from 10% to 30% and are available at providers identified in the provider directory with a "DP".

Discounts on refractive surgeries such as LASIK, RK and PRK

Providers listed in the provider directory with the "RF" designation will provide Superior Vision participants with a discount of 20% on refractive surgeries.

Website Address for Provider Directory and Benefit Description

http://da.state.ks.us/ps/subject/benlink.htm

Mailing address

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Customer Service Telephone Number

Toll free: 800-507-3800

SUPERIOR VISION SERVICES		BASIC PLAN	ENHANCED PLAN	BOTH PLANS
Benefit Type	Benefit Frequency	Network Provider	Network Provider	Non-Network Provider
Subject to $50 copay				
Eye Exam, M.D.	12 months	Covered in Full	Covered in Full	Up to $38.00
Eye Exam, O.D.	12 months	Covered in Full	Covered in Full	Up to $38.00
Subject to $25 materials copay				
Frame	12 months	Up to $100 Retail*	Up to $100 Retail*	Up to $45.00
Single Vision, Pair	12 months	Covered in Full	Covered in Full	Up to $31.00
Bifocal, Pair	12 months	Covered in Full	Covered in Full	Up to $51.00
Trifocal, Pair	12 months	Covered in Full	Covered in Full	Up to $64.00
Lenticular, Pair	12 months	Covered in Full	Covered in Full	Up to $80.00
Progressive lens, Pair	12 months	Not Covered	Covered up to $165**	Not Covered
High Index lenses	12 months	Not Covered	Covered up to $116**	Not Covered
Poly-carbonate lenses	12 months	Not Covered	Covered up to $116**	Not Covered
Scratch Coat	12 months	Not Covered	Covered in Full	Not Covered
UV Coat	12 months	Not Covered	Covered in Full	Not Covered
Not subject to materials copay				
Contact Lenses, Medically Necessary	12 months	Covered in Full	Covered in Full	Up to $210 retail
Contact Lenses, Elective-Cosmetic	12 months	Up to $150 retail*	Up to $150 retail*	Up to $105 retail

* Participants are responsible for any charges above the allowance.

** Participants may use only one of the lens allowances per purchase. Participants are responsible for any charges above the allowance.

- Participants can use either the contact lens benefit or the eyeglass benefit, but not both in the same Plan Year.
- Non-Network Claims - copay amount(s) is deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.

Coverage Level	Basic Plan	Enhanced Plan
Employee only	$2.13	$3.49
Emp/Spouse	$4.26	$6.98
Emp/Child(ren)	$3.84	$6.28
Emp/Family	$5.97	$9.77

HEARING IMPROVEMENT PROGRAM (K-SHIP)

K-SHIP is a hearing program utilizing the Hearing and Speech Departments at participating universities. Participants can receive a discount on certain hearing services from the Hearing and Speech Departments at the following universities:

- Fort Hays State University
- Kansas State University
- University of Kansas
- University of Kansas Medical Center
- Wichita State University

Employees who are enrolled in the Health Plan and their covered family members are eligible to receive a 10% discount off the cost of hearing evaluation and testing services. To maximize benefit options, contact your health plan to ask about coverage. If enrolled in HMO coverage, obtain a referral from your PCP before obtaining services. Participants do not have to apply for coverage or fill out any forms to be eligible for the discount. Simply tell the clinic you are a State of Kansas Health Plan participant at the time the appointment is made. Participants will be asked to show their prescription drug card at the appointment to verify eligibility. Contact information is available at:
http://da.state.ks.us/hcc/oekship.htm

KANELECT FLEXIBLE BENEFITS PROGRAM

KanElect is an Internal Revenue Code, Section 125 plan offered by the State of Kansas. Before enrolling in the KanElect Pretax Premium Option or KanElect Flexible Spending Accounts (FSA) Program, employees should review the enrollment information in this booklet. Additional information can be viewed in the Employee Benefits Guidebook at the following website: http://da.state.ks.us/ps/benefits.htm

KanElect Options

Pretax Premium Option – allows the employee to pay for the cost of employee sponsored Health Plan premiums on a pretax basis.

Health Care Flexible Spending Account – allows the employee to use pretax earnings to pay for certain incurred medical expenses allowed by the IRS but not reimbursed by medical, dental, prescription drug or vision insurance. Insurance premiums and other premiums are not reimbursable expenses in a FSA.

Dependent Care Flexible Spending Account – allows the employee to use pretax earnings to pay for work-related daycare expenses.

Enrollment

Employees who want to participate in 2004 for either the Health Care or the Dependent Care FSA must enroll during Open Enrollment regardless of current enrollment status.

Open Enrollment elections for 2004 will become effective on January 1, 2004.

How Much to Deposit

The minimum and maximum amounts eligible for deposit per **semi-monthly** deduction period are:

Health Care Flexible Spending Account		
Payroll Periods	Minimum	Maximum
- 24 deduction period employees	$8.00	$132.00
- 16 deduction period employees (regents)	$12.00	$198.00

Dependent Care Flexible Spending Account		
Payroll Periods	Minimum	Maximum
- 24 deduction period employees	$16.00	$208.33*
- 16 deduction period employees (regents)	$24.00	$312.50*

*Subject to tax filing status.

Expenses eligible for reimbursement are those incurred from January 1, 2004 through December 31, 2004 and filed by March 31, 2005.

Mailing Address

ASI
PO Box 6044
Columbia, MO 65205-6044

Telephone Number

Automated Infoline (24 hours) 800-366-4827
(Customer Service representatives available 8 a.m. to 5 p.m. on workdays)

Website Address http://www.asiflex.com

OPEN ENROLLMENT INSTRUCTIONS

Beginning October 1, 2003, State of Kansas employees can enroll online through the Employee Self Service Center for Plan Year 2004 Health Plans and Flexible Spending Accounts.

An employee must enter the Employee Self Service Center on the **accessKansas** website to enroll in the Health Risk Appraisal and receive a credit, to make Health Plan changes, or to participate or renew participation in a Flexible Spending Account for Plan Year 2004. Employees not wanting to make <u>any</u> changes to their Health Plan, and not wanting to enroll in the Health Risk Appraisal or Flexible Spending Accounts, are not required to enroll on-line.

The **Employee Self Service Center** is also the site all non-regents employees access to view pay advices.

Regents employees can use the Employee Self Service Center to participate in Open Enrollment and to view a confirmation statement of benefit changes.

Passwords:

- Current users of the Employee Self Service Center will enter their existing password.
- First time users of the Employee Self Service Center will be able to create an initial password by entering their birthdate (format must be "MM/DD/YYYY" including slashes) as the password. They will then be prompted to change the password to something personal that they will retain.

http://www.accesskansas.org/employee/

To Enroll

- Use a computer with Internet access when and where it is convenient – work, home, Job Service Centers, many public libraries.
- Go to the Employee Self Service Center website at http://www.accesskansas.org/employee/. Select "Employee Self Service Center".
- Select "Login". Follow the instructions on the screen (requires Employee ID and other member specific information)
- Update your profile by including an email address and setting up a secret question and answer.
- Select "Benefits Open Enrollment."
- Follow the on-screen instructions. Many screens include links that provide additional information regarding the topic.
- When finished, select '**Submit/save changes'.**
- Print a confirmation of selections.
- Logout and close the browser.

Forgot the password you created?

Answer your secret question online and receive a new password immediately on the screen. If necessary, call the Help Desk to receive a new password.

Need help on the website?

The help desk is open 24 hours a day and can be reached at (785) 296-1900. The help desk can only assist with signing in to the Employee Self Service Center. Staff cannot answer questions about benefit options. For benefit options questions, contact your agency's Human Resources office, email Benefits@da.state.ks.us or go to: http://da.state.ks.us/ps.benefits.htm

INFORMATION FOR COMPLETING OPEN ENROLLMENT

The Employee Benefits Guidebook is a complete listing of the rules regarding the benefits plans. The Guidebook is located on the State of Kansas website:

http://da.state.ks.us/ps/benefits.htm

Medical Insurance Plans

Eligibility for all plans is determined by county of residence (based on the city and state of residence). The Open Enrollment screen will display only those plans that are available in the employee's county of residence. For HMOs, the employee and all covered dependents must reside within the designated enrollment area for the State of Kansas group.

Medical and Prescription Drug Coverage

All employees and dependents with medical coverage will also have prescription drug coverage.

Dental Coverage

Single dental coverage is provided for all employees enrolled in medical coverage. Employees may choose to add dependent dental if dependent medical coverage is selected; the dependents enrolled in the dental plan must match those enrolled in the medical plan.

Vision Coverage

Plan Year 2003 vision plan enrollment will roll into Plan Year 2004 unless a change is made on-line. Employees may elect any level of coverage in either the Basic or Enhanced Superior Vision Plan regardless of enrollment in a medical or dental insurance plan. If you elect to enroll dependent children in medical and vision coverage, the same children must be enrolled in both.

Note: Employees may waive medical, drug, and dental coverage and still enroll in the voluntary vision plan.

Required Information

The following information is required for each employee and dependent covered by the Health Plan:

- Relationship (e.g., child, spouse, stepchild, etc.) Documentation to support proof of relationship or dependency is required.
- Full Name
- Social Security Number
- Gender
- Date of Birth
- PCP (Primary Care Physician) Number—for initial enrollment only on all HMO options. PCP designations should be made via on-line enrollment only if selecting a new HMO option. To change PCP at any time without changing carriers, call the HMO.

Dependents

Eligible dependents include, but are not limited to:

- An employee's lawful wife or husband. When the employee has been divorced from the lawful wife or husband, such spouse no longer qualifies as the employee's lawful wife or husband.
- An employee's unmarried child who:
  1. Is less than 23 years of age;
  2. Does not file a joint tax return with another taxpayer;
  3. Receives more than half of their support from the employee; and
  4. Is a U.S. citizen, a U.S. national or a resident of the U.S., Canada or Mexico at some time during the tax year.

For a more complete listing of those qualifying as a dependent, see the Employee Benefits Guidebook.

Qualifying Events

Open Enrollment is your annual opportunity to make changes to your health care coverage. You may not make changes to your health or dental elections until next year's Open Enrollment period unless you experience a qualifying event. Qualifying events may require or provide you with an opportunity to make changes to your coverage level and/or plan before the next Open Enrollment period.

You must contact your agency's Human Resources office and complete an enrollment or change form for all changes within 31 days of the qualifying event.

Qualifying events include, but are not limited to:

- Birth or adoption of a child
- Marriage
- Divorce
- Spouse's gain or loss of employment
- Death of spouse or dependent

For a complete list of qualifying events, see the Employee Benefits Guidebook.

Open Enrollment Checklist

Have you...

✔ Read all of the Open Enrollment materials?

✔ Attended an Open Enrollment meeting held in your area?

✔ Determined whether or not you want to make any changes to your current health plan?

✔ Called your health care provider's office to ask whether your doctor (or a doctor you wish to see) participates in the plan you have chosen and, if applicable, is accepting new patients?

✔ Submitted documentation to your personnel officer such as birth certificates or marriage license for dependents you are adding for the first time?

✔ Enrolled or re-enrolled for health or dependent care FSA?

✔ Elected to participate in the Health Risk Appraisal?

✔ Saved & submitted the on-line Open Enrollment form?

✔ Printed a summary of elections after selecting **'SUBMIT/SAVE'** in the on-line Open Enrollment system?